COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

August 10, 2015
12:30 – 3:30PM
COPIC, Mile High Room

Meeting Minutes

Commissioners Present: Bill Lindsay (chair), Cindy Sovine-Miller (vice-chair), Elisabeth Arenales, John Bartholomew (for Sue Birch), Jeffrey Cain, Greg D'Argonne, Steve ErkenBrack, Linda Gorman, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Chris Tholen
Staff: Lorez Meinhold and Cally King (Keystone Policy Center)

Action Items/Follow-up:

- Planning Committee to re-draft last point on the "Scope of Work" document to better articulate the charge from the General Assembly to address Physical Therapy and Physical Therapy co-pays.
- Planning Committee to re-share with Commissioners the draft outline of the November Commission report to the General Assembly.
- Commissioners should continue to ruminate on the Transparency topic and review the readings. At the next meeting, the Commission will talk about specific recommendations to make on Transparency and what to include in the November report regarding Transparency. Chris Tholen to share additional Transparency reading with Commissioners to help with this process.
- The Planning Committee will discuss how to best disseminate and catalogue readings for Commissioners and public to access.

Next Meeting: Friday, August 28th, 12:30 – 3:30PM at COPIC, Mile High Room

---

Meeting Summary:

I) Approval of Minutes

A) A motion for approval was given and seconded for the July 13th Meeting Minutes. There were no objections or further discussion to adopt the Minutes.

II) Priorities for the Commission – Bill Lindsay/Commissioners

(See meeting materials: "Scope of work")

A) Bill Lindsay provided guidance for the discussion on "Priorities for the Commission." Because the Commission has restructured and there are limited resources available, the Commissioners discussed the scope of work and how to prioritize topics moving forward given these constraints. The focus of the discussion was to prioritize topics and ensure they are in alignment with the charge given to the Commission from the General Assembly.

B) Commission Discussion:

1) The report due in November should include comments on what the Commission sees as the drivers in health costs, it would be too early to make any recommendations to the General Assembly at this point.

(a) Funding is important to include as well, in absence of additional funds the Commission should modify their work plan and make note of areas we would have liked to look at but lacked the funding and/or time to do so.

2) Need more clarity around the "markets" conversation and whether these should fall under "regulations."
   (a) Planning Committee discussed this topic as well, it is not included in the scope document but is part of the concept.
3) Medicaid management should be included, instead of just Medicaid waivers.
4) High deductible plans need to be looked at with regards to affordability and plan design. This is broader than the charge from the General Assembly and the Commission may not have the resources to take it on, but I believe we should look at it if possible.
5) To keep focus moving forward, is there anything missing from the list? The group can come back to these areas as we complete the initial list and if we find the time and additional funding.
   (a) Medicaid management
   (b) Pharmacy
   (c) Community health interventions
   (d) Markets and state regulations around markets – there are strong regulations in place but data flow has been slow to make good analysis happen. How well are new regulations working or not?
6) Is it possible to get this scope completed in the next 80 days?
   (a) Idea is that this could be the work plan for the Commission over the next 6-8 months; not necessarily to be completed for the November report.
7) How will development of the report to the General Assembly be managed?
   (a) The Planning Committee has built a rough outline that includes topic areas, discussion of decisions that have been made, and an outline of what the Commission will do after November.
   (b) Can you send an outline of the report in advance for Commissioners to give input?
      (i) Yes, we can share the work in progress with Commissioners.

III) Presentation and Discussion: Transparency – CHI/Commissioners

(See meeting materials: "Transparency presentation" and Aug 10 Transparency readings)

A) CHI provided a presentation to the Commissioners on the "Transparency" topic area. The presentation included an overview of the problem and how it contributes to cost, review of relevant research and literature, a look at what other states are doing executively and legislatively, examination of gaps in information, opportunities for cost savings in Colorado, and consideration of opposing viewpoints.

B) Commission Discussion/Questions:
   1) Astonished there isn't more data showing transparency will reduce costs.
      (a) We shouldn't be surprised at this result because price transparency is only one aspect of this. The transparency piece needs to be broader and longer term before we some sort of movement.
   2) From consumer perspective, Consumers Union has done a lot of work looking at what influences consumer behavior. Cost isn't the principle factor in consumer decisions – they are influenced by quality of care, doctor's orders, and consumers, in general, usually have no idea there is a difference in quality between hospitals and providers (many assume it is a level playing field).
      (a) Not all consumers fit neatly into these buckets.
   3) The Research Committee had recommended the following on Transparency and I suggest we look at these more:
      (a) Recommended the All Payers Claim Database should receive the level of support they require to do their job.

(b) The Committee attempted to retrieve data from Texas legislation passed in 2015 (House Bill 1624) relating to transparency of certain information related to certain health benefit plan coverage, but have been unable to obtain detailed information on this legislation. The bill has an enactment date of September 2015.

4) On Slide 8 (BCHAG experience: Minnesota), is there a comparative statistic for Colorado?
   (a) Not across markets, but might be able to look at individual plans in Colorado. The information was from a contained group.
   (b) We're also in the midst of a lot of change in health care reform and may want to look at consumers from 2014-15. When we look for documentation we need to realize there are many changes going on.
   (c) Cindy asked CHI to reach out to health plans and get their insight on what a 1 percent premium increase would mean to them. What is the impact and overall intake on enrollment? Would also like to reach out to the rural communities for their input.
5) The Commission needs to be careful in this topic, transparency does have an impact on providers, consumers and health insurance plans. The question is, "transparency for whom?" The other piece to this topic is the quality of information available; information isn't always very detailed or specific. The Commission will have to be careful how we categorize observations in our report.
   (a) It's important to look at information gaps because there aren't good metrics on transparency. Consumers are trapped in care systems which need to be looked at to really understand the issues. There are a lot of patients opting out of Medicare plans when they get really sick.
   (b) The CalPERS example harnesses the American shopper and shows where there is choice.
   (c) Part of the challenge is what's the population we're talking about in terms of behavior we're trying to affect? Individuals, providers, consumer, etc.?
6) When we think about transparency, we think about the industry, but the difficulty is how do consumers use this information? Is there any data that can help us understand how consumers have used the data to date?
   (a) The reading showed that providers do seem to respond to data that shows significant differentials in pricing.
7) Difficulty is that this can be very complicated and we need to deal with the statistical validity of the numbers. You can provide the data but it becomes very complicated.
   (a) Data is available for self-insured and fully-insured employers in terms of total spend. We want to be thoughtful and see if there is a problem.
   (b) If employers had information like - hospital x produced good outcomes and was more successful than hospital Y – how challenging is it to get that data and provide to employers to make decisions on where their employees are covered in Colorado?
      (i) There are a lot of mitigating factors and it goes back to making sure we're appropriate in making sure the information provided is something people can accurately rely on to get the information.
8) There are three areas to address in the presentation:
   (a) Slide 3 (How does the Problem Contribute to Cost?): relative to "moral hazard" – not sure I agree with that concept.
   (b) Slide 3: "Lack of skepticism about ordering more tests" – for the most part, patients don't question their physician's decision to run more tests. Physicians usually do this in fear of litigation for not running all the tests possible. I think pricing for a lot of fee-for-service tests are fixed in nature and don't think hospitals cherry-pick the more expensive tests.

(c) Slide 15 (What are the Opposing Viewpoints?): I agree providers respond to costs in data. Patients respond to emergency situations with what's closest, not what the costs are. There is an underlying assumption that providers give good quality care across the board. I don't think consumers will ever get to the point where health care providers are.

9) Goes back to the questions of who are we trying to influence? Need to raise education and awareness of people as they become more concerned with cost of health care.
   (a) When it comes to transparency the focus has switched to making the provider and patient transparent to the government; not providing more information to consumers and providers.
      (i) As soon as consumers don't like what's going on, they ask the government to fix the problem. It's not as easy as providers and insurance companies working out these details without government intervention.
10) We haven't discussed whether or not people see providers inside or outside of their networks and what the cost is to see an out-of-network provider for the consumer and the health plan. There is a lot of back and forth about the amount of cost of unknown and inadvertent use of out-of-network providers.
11) The Transparency topic seems to need to be taken to a more granular level between doctor and patient. It's not clearly understood by the patient why an expensive piece of equipment was used; we need better communication between providers, hospitals and the patient.
12) The group's sentiment seems to be transparency has its benefits in terms of information that is collected in a responsible way and keeping the information as accurate as possible.
   (a) It's also making sure the information is consumer friendly.

C) Next Steps: Commissioners should continue to ruminate on this topic and look at the readings. During the next meeting, the Commission will talk about what specific recommendations we can make on Transparency and what we would like to include in our report regarding transparency.
1) Chris Tholen to share additional Transparency reading with Commissioners to help with this process. **(FOLLOW-UP)**

IV) Public Comment:

A) George Swan, retired hospital administrator: Congratulations for putting up the website – availability of reading material is incredible and very advanced. First comment, "How well is data transparency working?" is a great question – what does the public have a right to expect in order to make an effective decision? I do not agree that transparency has no effect on patients and providers. In terms of reduction of testing, I haven't heard any talk about CORHIO and what they can do; this seems to be a big part of the transparency topic. Second, congratulations for being the first website to provide pivot tables with this information. I'd also like to comment on the CHI cost table, it provides estimates from 2013 which is a long time without any historical information. There is standard information that should be included in data like hospital satisfaction scores.
1) Commissioner comments/questions:
   (a) To be clear, the Commission is not saying transparency isn't valuable, the only question we have is if it actually improves costs and leads to cost reduction which is the focus of our work. It's not at all that we don't believe transparency brings important things to the table.
   (b) Is it correct that pivot tables are an Excel spreadsheet function? If we are going to provide public transparency is this something accessible to people?
      (i) There are free readers and pivot tables can be loaded onto a website that is accessible. Any website can do a pivot table, it doesn't need to be an excel spread sheet.

V) Workforce: Identify buckets to review for September Commission meeting – CHI/Commissioners

(See meeting materials: "Workforce priorities")

A) The Research Committee had previously identified buckets to discuss under the Workforce topic area; however, the Commission will need to prioritize which buckets are the most important to discuss and make recommendations on because limited time and funding will not allow the Commission to take on all the workforce bucket areas previously outlined by the Research Committee. CHI provided background on some of the potential workforce buckets for the Commission to consider how they would like to focus the September meeting presentation and discussion.

B) Commission Discussion:

1) Surprised the shortage of professional health care workers (nurses, pharmacists, respiratory therapists, etc.) is not included. There seems to be some immediacy to this issue in the Metro area and there will be a large problem created with hospitals going under, physicians paying more money and not being able to provide.
   (a) The third bucket (Investment in Primary Care Providers) is intended to look at that issue.
2) There are items not included in this presentation that were discussed during the Research Committee including Licensing and Academic Programs. The Committee never talked about "investments in primary care." The list looks like the Commission just wants to increase primary care providers which is very debatable if that is even the correct approach.
   (a) There were about 10 bucket areas identified during the Research Committee meeting, the four included the presentation today are a flavor of a couple things CHI has learned from initial research. The list provided today is not intended as an end-all, be-all list but is intended to start the conversation on what can be looked at.
3) With regards to savings attributed to Nurse Practitioners (NP), today to be a NP you need a doctorate whereas in the past you didn't need that much education - is there data showing the long-term impact on the cost of changing standards?
   (a) Regardless of that requirement, we do have NPs demanding lower salaries than their counterparts.
   (b) There are papers and data on licensing & credentialing and how the length of a training period affects cost.
4) Where does "Workforce" fit into the Commission's scope?
   (a) The Scope really drives the buckets under the identified topic areas, including workforce. The 208 report asks the Commission to look at provider shortages. If we don't have the time or energy to look at this fully, we should articulately note in the report the areas we would have liked to look at under the topic but didn't have the resources or time to actually look into it.
5) Commissioner request to have full access to articles and information that are being used to define the buckets. Can these be put on the website? Would like to see documents that are being discussed and put forward; those readings should be available to everyone, including the public.
   (a) If we go this route, would like to see "Commission readings" that are required for the upcoming meetings with a different folder for "suggested readings" that come from CHI and Commissioners as additional/optional readings.
      (i) One issue is Commissioner access to articles that are on pay databases
      (ii) The Planning Committee will discuss how to best disseminate and catalogue readings for Commissioners and public to access **(FOLLOW-UP)**

C) Buckets to focus on under "Workforce" at September meeting:

1) Provider shortages

2) Licensing
3) Suggestion to include provider pay at different levels.
   (a) This gets dangerously close to trying to boil the entire ocean. The Commission's charge is to focus on cost and I don't think we can tackle issues like this with the degree of resources needed with the time period and funding available.
   (b) We can identify this as a suggested area to address and explore, but note that this group didn't have the time or funding to take it on.

VI) Presentation: Available Data on Spending in Colorado – CIVHC

(See meeting materials: "All Payer Claims Database")

A) The Center for Improving Value in Health Care (CIVHC) provided a presentation to the Commission on the Colorado All Payer Claims Database (APCD). The presentation provided background on CIVHC, how and where they collect data for the APCD, who the data collection is for, and how to access the various data sets available online.

B) Commission Comments/Discussion:

1) When we look at commercial populations, specifically in Pitkin County, my understanding is that the data is tracked by patient not by provider. Hypothetically, people living in Pitkin have more resources so they could be choosing in-patient services somewhere else because they have the means to do it. Could it be true that the higher costs seen in Pitkin County could be attributed more to the patients' choices rather than the actual cost for services in Pitkin?
   (a) There is truth to that assumption. CIVHC can generate analytics on site of service but have trouble rendering data that is accurate and reliable in this area and have a lot of work to do before we can go live with this kind of information.
2) It was mentioned that at some point CIVHC can be more specific in terms of facility based care – when do you expect to see this?
   (a) Will know timeline later this year. We're looking at improving inbound files, provider indexes that are coming in, and have a few outstanding items. When you're merging 20 different commercial insurance providers' data, there's a lot to go through. There will be improvement soon.
3) Do you see variances in county data a lot?
   (a) It depends on the data as it comes in and the size of the payers. CIVHC is always adding new data but are still lacking in some data sources. There is also a small numbers issue in play as you break down into smaller and smaller geographic areas.
4) In CIVHC's opinion on value from a transparency perspective, is there anything the Commission can recommend to make it more possible to have the kind of data that helps show the difference in cost between providers since that appears to drive behavior that reduces cost?
   (a) Making some things publicly available could help. CIVHC has a lot of information and the key is increasing the value of it by finding ways to merge different data elements together. Something that could help it is to ease partnerships with other organizations to bring different data elements together. It's also useful to think of the value of transparency through the lens of individual stakeholders (providers, employers, consumers, etc.). The Commission should look at a study from the California HealthCare Foundation analyzing New Hampshire's cost transparency project – *Moving Markets: Lessons from the New Hampshire's Health Care Price Transparency Experiment*
5) How much does it cost CIVHC to provide all this information?
   (a) CIVHC is a $5M organization and APCD comprises about half of that budget.

VII) Public Comment:

A) George Swan: On workforce analysis, I've been to the licensing website and there is an enormous opportunity there to answer questions about aging of providers, prevalence by county is available at CHI and I turned that information into a pivot table. The aging of the population is another side to look at. In regard to CIVHC, there is a whole question on real-time data. One of the best ways to look at this is the pivot table on the website on Behavior Risk Factor system that shows when data was made available. Timeliness needs to be a consideration on any data exercise. I'm surprised Medicare data isn't more readily available, it should be easily done. The Commission should look at the need of communities when considering transparency – data needs to be provided at the community level and the public health officer is the key to this in each community. It takes an hour to make a pivot table which better relays the data. Johns Hopkins study on ten volume sensitive procedures should be included, waste fraud and abuse should be included

VIII) Updates – Bill Lindsay/Commissioners

A) As part of the Commission's charge to look at Physical Therapy and PT co-payments, we have completed a contract with the Milliman group to do this analysis.
   1) Goal to have data and their report back for Commission review prior to October so we can ask questions and include in the report to the General Assembly for November.

B) Next Meeting: Friday, August 28th, 12:30 – 3:30pm